



**By Telephone:** Those members who do not have access to CVS Caremark via the internet can learn more about the program by calling CVS Caremark Member Services at 1-800-241-3260, 24 hours a day, 7 days a week.

## WVCHIP Medical Reimbursement

(Please print or type.)

Member's (child) Name \_\_\_\_\_  
Last First Middle

Identification Number \_\_\_\_\_ Member's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Address \_\_\_\_\_  
\_\_\_\_\_

Phone Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policyholder's Sex  Male  Female

Nature of Illness or Injury \_\_\_\_\_

Was illness or injury related to accident?  Yes  No

If yes, complete the following:

Date of accident: \_\_\_\_\_

Location of accident: \_\_\_\_\_

Was another party at fault?  Yes  No

Was illness or injury any way work related?  Yes  No

I certify that the above is correct and that I am claiming benefits only for charges incurred by the patient named above. I further authorize the release of any medical information necessary to process this claim.

Signature of Policyholder's

Parent / Guardian / Representative \_\_\_\_\_ Date \_\_\_\_\_

Itemized bills must accompany this claim form. These bills must include the following information:

- 1) Name of child covered by WVCHIP
- 2) The WVCHIP Policyholder's identification number
- 3) The nature of the illness or injury
- 4) Date(s) of service
- 5) A complete description of each service
- 6) The amount charged for each service
- 7) Diagnosis and procedure codes for each illness, condition and procedure
- 8) The provider's name, address, and NPI number

**Mail to:**  
**DXC Technology**  
**P.O. Box 3732**  
**Charleston, WV**  
**25337**